



# Weston Family Eyecare

Dr. Jane M. Therrien

Board Certified Optometric Physician

### Patient Information:

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Patient's Birthdate \_\_\_\_\_  
(If patient is a minor)

Mailing Address \_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip Code) Work Phone # (\_\_\_\_) \_\_\_\_\_

E-mail address (optional) \_\_\_\_\_ Occupation \_\_\_\_\_

Employer or School (if patient is a student) \_\_\_\_\_ Grade \_\_\_\_\_

SS # \_\_\_\_\_ Drivers License # \_\_\_\_\_ State \_\_\_\_\_  
(if using insurance) (if paying by check)

How did you find out about our office? \_\_\_\_\_

My visit today is for (circle one): glasses contact lenses laser vision correction office visit  
Other (please explain) \_\_\_\_\_

Are you considering new glasses? Yes/No Contacts Yes/No Sunglasses Yes/No

Date of last eye examination: \_\_\_\_\_ Doctor: \_\_\_\_\_

**Social History:** This information is kept strictly confidential. However you may discuss it directly with the doctor if you prefer.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No

Do you use tobacco products? Yes No If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol? Yes No If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs? Yes No If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with any sexually transmitted disease? Yes No  
If yes, please give details: \_\_\_\_\_

### Medical History:

Are you pregnant and/or nursing at this time? Yes No

List any health problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you taking any medications (including eye drops and over-the counter) and what for? Yes No  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications? Yes No

(if so, please list) \_\_\_\_\_

### Eye History:

Eye injuries Yes No  
(foreign objects, black eye, etc.)

Eye disease Yes No  
(cataract, glaucoma, macular degeneration, etc.)

Eye surgery Yes No  
(cataract, laser vision correction, etc.)  
If yes to any of the above, please tell what and when:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you wear contacts? Yes No

If so, type \_\_\_\_\_

### Review of Systems:

Do you currently, or have you ever had any problems in the following areas?

#### Eyes (Ocular symptoms)

Eye pain or soreness	Yes	No
Fatigue/tired eyes	Yes	No
Dry/gritty feeling	Yes	No
Redness	Yes	No
Burning	Yes	No
Itching	Yes	No
Excess watering	Yes	No
Mucous discharge	Yes	No
Chronic infections	Yes	No
Squinting	Yes	No
Glare/light sensitivity	Yes	No
Halos around lights	Yes	No
Double vision	Yes	No
Loss of vision	Yes	No
Blurred vision	Yes	No
Flashes	Yes	No
Floaters	Yes	No

#### Constitutional

Fever	Yes	No
Weight loss or gain	Yes	No

#### Skin

Rosacea	Yes	No
Metal allergies	Yes	No

#### Ear, Nose, Throat, Mouth

Allergies/hay fever	Yes	No
Sinus infections	Yes	No
Hearing Loss	Yes	No

#### Respiratory

Asthma	Yes	No
Chronic bronchitis	Yes	No
Emphysema	Yes	No

#### Vascular/Cardiovascular

Heart disease/problems	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Stroke	Yes	No

#### Gastrointestinal

Acid reflux	Yes	No
Intestinal problems	Yes	No
Liver/spleen problems	Yes	No

#### Endocrine

Thyroid/other glands	Yes	No
Diabetes	Yes	No

#### Genitourinary

Genitals/kidney/bladder	Yes	No
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#### Lymphatic/hematologic

Anemia	Yes	No
Bleeding	Yes	No

#### Bones/joints/muscles

Rheumatoid arthritis	Yes	No
Muscle/joint pain	Yes	No

#### Neurological

Headaches	Yes	No
Seizures	Yes	No
Alzheimer's	Yes	No
Parkinson's	Yes	No

#### Psychiatric

Psychiatric	Yes	No
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#### Immune system

Immune system	Yes	No
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